

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0041699</u></p> <p>Facility Name: <u>Heritage Manor-Springfield</u></p> <p>Address: <u>900 N RUTLEDGE</u> <u>Springfield</u> <u>62702</u> Number City Zip Code</p> <p>County: <u>SANGAMON</u></p> <p>Telephone Number: <u>(217) 789-0930</u> Fax # ()</p> <p>IDPA ID Number: <u>371359387001</u></p> <p>Date of Initial License for Current Owners: <u>1996</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: _____ Telephone Number: <u>()</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2004</u> to <u>12/31/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Craig L. Ater</u></td> </tr> <tr> <td></td> <td>(Title) <u>Senior V.P. and Chief Financial Officer</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>(309) 823-7135</u> Fax # () _____</td> </tr> </table> <p style="text-align: center;">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>Craig L. Ater</u>		(Title) <u>Senior V.P. and Chief Financial Officer</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>(309) 823-7135</u> Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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Facility Name & ID Number Heritage Manor-Springfield# 0041699 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>178</u>	Skilled (SNF)	<u>178</u>	<u>65,148</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>178</u>	TOTALS	<u>178</u>	<u>65,148</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>32,469</u>	<u>16,384</u>	<u>10,046</u>	<u>58,899</u>	8
9	SNF/PED			<u>0</u>		9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,469</u>	<u>16,384</u>	<u>10,046</u>	<u>58,899</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.41%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1996

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 10,046Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Heritage Manor-Springfield

0041699

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	337,743	25,278		363,021		363,021	6,647	369,668		1
2	Food Purchase		241,556		241,556		241,556		241,556		2
3	Housekeeping	176,819	41,542		218,361		218,361		218,361		3
4	Laundry	116,618	30,106		146,724		146,724		146,724		4
5	Heat and Other Utilities			148,450	148,450		148,450	2,035	150,485		5
6	Maintenance	157,510	61,076	46,104	264,690		264,690	23,839	288,529		6
7	Other (specify):*										7
8	TOTAL General Services	788,690	399,558	194,554	1,382,802		1,382,802	32,521	1,415,323		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,933,913	216,144	10,632	3,160,689		3,160,689		3,160,689		10
10a	Therapy		687,830	461,073	1,148,903	(888,583)	260,320	449,731	710,051		10a
11	Activities	101,977	5,968		107,945		107,945		107,945		11
12	Social Services	102,725	40		102,765		102,765		102,765		12
13	Nurse Aide Training							3,521	3,521		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,138,615	909,982	489,705	4,538,302	(888,583)	3,649,719	453,252	4,102,971		16
	C. General Administration										
17	Administrative	64,808			64,808		64,808	119,673	184,481		17
18	Directors Fees							9,676	9,676		18
19	Professional Services			386,052	386,052		386,052	(345,126)	40,926		19
20	Dues, Fees, Subscriptions & Promotions			124,106	124,106	(97,722)	26,384	(5,431)	20,953		20
21	Clerical & General Office Expenses	298,393	27,722	30,789	356,904		356,904	240,901	597,805		21
22	Employee Benefits & Payroll Taxes			827,538	827,538		827,538	62,055	889,593		22
23	Inservice Training & Education			880	880		880	984	1,864		23
24	Travel and Seminar			7,385	7,385		7,385	(5,386)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			118,873	118,873		118,873	3,633	122,506		26
27	Other (specify):*			100,113	100,113		100,113	(100,113)			27
28	TOTAL General Administration	363,201	27,722	1,595,736	1,986,659	(97,722)	1,888,937	(19,134)	1,869,803		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,290,506	1,337,262	2,279,995	7,907,763	(986,305)	6,921,458	466,639	7,388,097		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Heritage Manor-Springfield

#0041699

Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			291,194	291,194		291,194	20,694	311,888			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			111,647	111,647		111,647	(2,328)	109,319			32
33	Real Estate Taxes			112,855	112,855		112,855		112,855			33
34	Rent-Facility & Grounds							11,781	11,781			34
35	Rent-Equipment & Vehicles			5,457	5,457		5,457	4,638	10,095			35
36	Other (specify):*											36
37	TOTAL Ownership			521,153	521,153		521,153	34,785	555,938			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					888,583	888,583		888,583			39
40	Barber and Beauty Shops			17,696	17,696		17,696		17,696			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					97,722	97,722		97,722			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			17,696	17,696	986,305	1,004,001		1,004,001			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,290,506	1,337,262	2,818,844	8,446,612		8,446,612	501,424	8,948,036			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **Heritage Manor-Springfield**# **0041699**

Report Period Beginning:

01/01/2004

Ending:

12/31/2004**VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(2,328)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(905)	20		17
18	Fines and Penalties				18
19	Entertainment	(19,929)	24		19
20	Contributions	(113)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,646)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(100,000)	27		24
25	Fund Raising, Advertising and Promotional	(11,067)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (145,988)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	647,412		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 647,412		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 501,424		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heritage Manor-Springfield

ID# 0041699

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(905)	20
18			18
19			24
20		(113)	27
21			21
22		(11,646)	19
23			23
24		(100,000)	27
25		(11,067)	20
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(123,731)	49

Summary A

12/31/2004

(to Sch V, col.7)

[illegible]

Summary B

12/31/2004

12/31/2004

[illegible]

Facility Name & ID Number Heritage Manor-Springfield# 0041699

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V	10a	Adjustment for Related Organization	419,050	GreenTree Therapy	100.00%	706,119	287,069	2
3	V								3
4	V	19	Adjustment for Related Organization	363,906	Heritage Enterprises, Inc.	100.00%		(363,906)	4
5	V								5
6	V	10a	Adjustment for Related Organization	683,898	GreenTree Pharmacy	100.00%	846,560	162,662	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,466,854			\$ 1,552,679	\$ * 85,825	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Springfield# 0041699Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 6,647	\$ 6,647
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				2,035	2,035
20	V	6 Maintenance				23,839	23,839
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				3,521	3,521
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				119,673	119,673
30	V	18 Directors Fees				9,676	9,676
31	V	19 Professional Services				30,426	30,426
32	V	20 Fees, Subscription, Promotions				6,541	6,541
33	V	21 Clerical & General Office Expenses				240,901	240,901
34	V	22 Employee Benefits & Payroll Taxes				62,055	62,055
35	V	23 Inservice Training & Education				984	984
36	V	24 Travel and Seminar				14,543	14,543
37	V	25 Other Admin. Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				3,633	3,633
39	Total		\$			\$ 524,474	\$ * 524,474

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Springfield# 0041699Report Period Beginning: 01/01/2004Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	27 Other	\$	Heritage Enterprises, Inc.		\$ 0	\$
16	V	30 Depreciation				20,694	20,694
17	V	31 Amortization of Pre-Op & Org				0	
18	V	32 Interest				0	
19	V	33 Real Estate Taxes				0	
20	V	34 Rent-Facility & Grounds				11,781	11,781
21	V	35 Rent-Equipment & Vehicles				4,638	4,638
22	V	36 Other				0	
23	V	38 Medically Nec Transportation				0	
24	V	39 Ancillary Service Centers				0	
25	V	40 Barber and Beauty Shops				0	
26	V	41 Coffee and Gift Shops				0	
27	V	42 Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 37,113	\$ * 37,113

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises			50.00					\$ 9,676	Line 18	1
2											2
3	Memorial Health Ventures			50.00							3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,676		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor-Springfield# 0041699

Report Period Beginning:

01/01/2004Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	Beds	2,403	24	\$ 89,729	\$ 89,729	178	\$ 6,647	1
2	2 Food Purchase	Beds	2,403	24	0	0	178	0	2
3	3 Housekeeping	Beds	2,403	24	0	0	178	0	3
4	4 Laundry	Beds	2,403	24	0	0	178	0	4
5	5 Heat & Other Utilities	Beds	2,403	24	27,471	0	178	2,035	5
6	6 Maintenance	Beds	2,403	24	321,832	76,617	178	23,839	6
7	7 Other	Beds	2,403	24	0	0	178	0	7
8	9 Medical Director	Beds	2,403	24	0	0	178	0	8
9	10 Nursing & Medical Records	Beds	2,403	24	0	0	178	0	9
10	11 Activities	Beds	2,403	24	0	0	178	0	10
11	12 Social Service	Beds	2,403	24	0	0	178	0	11
12	13 Nurse Aide Training	Beds	2,403	24	47,533	39,159	178	3,521	12
13	14 Program Transportation	Beds	2,403	24	0	0	178	0	13
14	15 Other	Beds	2,403	24	0	0	178	0	14
15	17 Administrative	Beds	2,403	24	1,615,588	1,615,588	178	119,673	15
16	18 Directors Fees	Beds	2,403	24	130,630	0	178	9,676	16
17	19 Professional Services	Beds	2,403	24	410,747	0	178	30,426	17
18	20 Fees, Subscription, Promotions	Beds	2,403	24	88,297	0	178	6,541	18
19	21 Clerical & General Office Expense	Beds	2,403	24	3,252,161	2,929,944	178	240,901	19
20	22 Employee Benefits & Payroll Tax	Beds	2,403	24	837,746	0	178	62,055	20
21	23 Inservice Training & Education	Beds	2,403	24	13,283	0	178	984	21
22	24 Travel and Seminar	Beds	2,403	24	196,325	0	178	14,543	22
23	25 Other Admin. Staff Transportation	Beds	2,403	24	0	0	178	0	23
24	26 Insurance-Prop.Liab.Malpract	Beds	2,403	24	49,040	0	178	3,633	24
25	TOTALS				\$ 7,080,382	\$ 4,751,037		\$ 524,474	25

Facility Name & ID Number Heritage Manor-Springfield# 0041699

Report Period Beginning:

01/01/2004Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27 Other	Beds	2,403	24	\$	\$	178	\$	1
2	30 Depreciation	Beds	2,403	24	279,369		178	20,694	2
3	31 Amortization of Pre-Op & Org	Beds	2,403	24			178		3
4	32 Interest	Beds	2,403	24			178		4
5	33 Real Estate Taxes	Beds	2,403	24			178		5
6	34 Rent-Facility & Grounds	Beds	2,403	24	159,040		178	11,781	6
7	35 Rent-Equipment & Vehicles	Beds	2,403	24	62,608		178	4,638	7
8	36 Other	Beds	2,403	24			178		8
9	38 Medically Nec Transportation	Beds	2,403	24			178		9
10	39 Ancillary Service Centers	Beds	2,403	24			178		10
11	40 Barber and Beauty Shops	Beds	2,403	24			178		11
12	41 Coffee and Gift Shops	Beds	2,403	24			178		12
13	42 Other	Beds	2,403	24			178		13
14							178		14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 501,017	\$		\$ 37,113	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank of Springfield		xx	Mortgage	\$17,720.00	05/01/02	\$ 2,800,000	\$ 2,531,466	05/1/07	variable	\$ 111,132	1	
2	Bank of Springfield		xx	Mortgage -- Loan fees							515	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Central Office Allocation		xx	Working Capital								6	
7	Central Office Allocation		xx	Working Capital								7	
8												8	
9	TOTAL Facility Related				\$17,720.00		\$ 2,800,000	\$ 2,531,466			\$ 111,647	9	
	B. Non-Facility Related*												
10	Interest Income										(2,328)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (2,328)	14	
15	TOTALS (line 9+line14)						\$ 2,800,000	\$ 2,531,466			\$ 109,319	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Heritage Manor-Springfield**# **0041699** Report Period Beginning: **01/01/2004** Ending: **12/31/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$	114,707		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	111,005		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,702)		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	116,557		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	112,855		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1999	88,571	8		
	2000	111,306	9		
	2001	104,972	10		
	2002	110,337	11		
	2003	111,275	12		
				FOR OHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Heritage Manor-Springfield COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0041699

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 38,805

B. General Construction Type:
 Exterior
 brick
 Frame
 steel
 Number of Stories
 4

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	land			\$ 630,000	1
2					2
3	TOTALS			\$ 630,000	3

Facility Name & ID Number Heritage Manor-Springfield

0041699

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	178				\$ 1,900,000	\$		\$	\$	\$	4
5					1,648,258						5
6											6
7											7
8											8
	Improvement Type**										
9	1985 Improvements		1985		26,076						9
10	1986 Improvements		1986		216,545						10
11	1987 Improvements		1987		593,121						11
12	1988 Improvements		1988		29,321						12
13	1989 Improvements		1989		1,095						13
14	1990 Improvements		1990		939						14
15	1991 Improvements		1991		32,022						15
16	1992 Improvements		1992		32,593						16
17	1993 Improvements		1993		105,986						17
18	1994 Improvements		1994		59,542						18
19	1995 Improvements		1995		36,126						19
20	Laundry Chute		1996		4,926						20
21	Door Alarm		1996		8,533						21
22	Garbage Disposal		1996		1,113						22
23	Elevator		1996		11,439						23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							20,695	20,695		34
35	Book Depreciation					221,492		221,492		2,114,656	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Vent Shaft	1997	\$ 6,267	\$		\$	\$	\$	37
38	Fire Dampers	1997	510						38
39	Computer Cabling	1997	14,518						39
40	Rehab Therapy Room	1997	7,391						40
41	Air Conditioner--Chiller	1997	47,954						41
42	Remodel First Floor	1997	27,570						42
43									43
44	Landscape	1998	2,410						44
45	Vent Work	1998	7,018						45
46	Asphalt Ramp	1998	850						46
47	Room Remodel	1998	1,142						47
48									48
49	Code Alert	1999	7,829						49
50	Wall Paper	1999	704						50
51	Remodel Office Interior	1999	1,248						51
52	Elevator Repair	1999	2,697						52
53	Carpet	1999	1,097						53
54									54
55	Shed Yardmate	2000	522						55
56	A/C Rooftop Unit	2000	2,937						56
57	Sewerline Repair	2000	1,482						57
58									58
59	Facility Renovation--Materials	2001	745,911						59
60	Facility Renovation--Labor	2001	1,463						60
61	Facility Renovation--Interior Design	2001	69,313						61
62	Fire Alarm System	2001	8,718						62
63	Sewer Line Repair	2001	1,787						63
64									64
65	Facility renovations: Paint , wallpaper, fixtures , floor coverings for all resident								65
66	rooms including hallways and common areas								66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,668,973	\$ 221,492		\$ 242,187	\$ 20,695	\$ 2,114,656	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,668,973	\$ 221,492		\$ 242,187	\$ 20,695	\$ 2,114,656	1
2	Landscape Design	2002	500						2
3	Freezer Compressor	2002	3,834						3
4	Smoke Detectors	2002	2,560						4
5	Facility Renovation--Materials	2002	186,172						5
6	Facility Renovation--Labor	2002	3,561						6
7	Facility Renovation--Interior Design	2002	15,497						7
8	Phone System	2002	2,064						8
9									9
10	Door Security	2003	2,597						10
11	Generator	2003	20,145						11
12	Door Replacement	2003	1,216						12
13	Generator Replacement	2003	9,244						13
14	Elevator Repair	2003	12,378						14
15	Shower Room Remodel	2003	17,153						15
16	Hallway carpet	2003	3,889						16
17	Boiler Door	2003	854						17
18									18
19	Shower Room Remodel	2004	37,959						19
20	Elevator Repair	2004	96,846						20
21	Condensing Unit	2004	7,204						21
22	Privacy Door	2004	1,226						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,093,872	\$ 221,492		\$ 242,187	\$ 20,695	\$ 2,114,656	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,211,215	\$ 69,702	\$ 69,702	\$		\$ 1,061,548	71
72	Current Year Purchases	33,610						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,244,825	\$ 69,702	\$ 69,702	\$		\$ 1,061,548	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,968,697	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 291,194	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 311,889	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,695	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,176,204	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 10,095 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		
2	Licensed Speech and Language Development Therapist		hrs			57,726				57,726	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs			404,391	3,932			408,323	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts				846,560			846,560	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):					42,023				42,023	13
14	TOTAL			\$		\$ 748,142	\$ 850,492		\$	1,598,634	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 65,807	\$	1
2	Cash-Patient Deposits	17,207		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,112,182		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,390		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,339		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,246,925	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	630,000		13
14	Buildings, at Historical Cost	6,093,872		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,244,825		16
17	Accumulated Depreciation (book methods)	(3,176,204)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,639,828		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,432,321	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,679,246	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 184,743	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,207		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	116,557		32
33	Accrued Interest Payable	10,954		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 329,461	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,731,466		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,731,466	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,060,927	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,618,318	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,679,245	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,579,746	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,579,746	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	113,572	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(75,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 38,572	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,618,318	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,621,522	1
2	Discounts and Allowances for all Levels	(2,568,913)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,052,609	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,291,363	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,291,363	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,312	12
13	Barber and Beauty Care	23,994	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,192,524	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(269)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,220,561	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,328	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,328	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,566,861	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,382,802	31
32	Health Care	4,538,302	32
33	General Administration	1,986,659	33
	B. Capital Expense		
34	Ownership	521,153	34
	C. Ancillary Expense		
35	Special Cost Centers	17,696	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		6,677	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,453,289	40
41	Income before Income Taxes (line 30 minus line 40)**	113,572	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 113,572	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number Heritage Manor-Springfield

0041699

Report Period Beginning: 01/01/2004

Ending:

12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,936	2,080	\$ 57,551	\$ 27.67	1
2	Assistant Director of Nursing	2,170	2,354	52,557	22.33	2
3	Registered Nurses	27,521	29,983	644,402	21.49	3
4	Licensed Practical Nurses	45,498	49,442	865,677	17.51	4
5	Nurse Aides & Orderlies	108,225	114,416	1,297,875	11.34	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,499	1,622	15,851	9.77	8
9	Activity Director					9
10	Activity Assistants	11,655	12,447	101,977	8.19	10
11	Social Service Workers	1,902	2,103	102,725	48.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,065	38,583	337,743	8.75	15
16	Dishwashers					16
17	Maintenance Workers	15,601	17,047	157,510	9.24	17
18	Housekeepers	21,840	23,456	176,819	7.54	18
19	Laundry	10,175	10,989	116,618	10.61	19
20	Administrator	1,900	2,080	64,808	31.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,379	21,921	298,393	13.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	305,366	328,523	\$ 4,290,506 *	\$ 13.06	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	18,000		36
37	Medical Records Consultant	0		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,134		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	0		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 22,134		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0		50
51	Licensed Practical Nurses	0		51
52	Nurse Aides	0		52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Heritage Manor-Springfield

STATE OF ILLINOIS

0041699

Report Period Beginning: 01/01/2004

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Ending: 12/31/2004

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 97,722
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 10,670
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Not available at this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

Country										Year										Population (millions)										GDP (billion USD)										Life expectancy (years)										Infant mortality (per 1,000 live births)										Unemployment (%)										Urban population (%)										Renewable energy consumption (%)										Internet usage (%)										Gender inequality index										Human Development Index																			
Albania										2020										2.8										12.5										75										77										18										12										55										15										65										0.65										0.75									
Algeria										2020										4.1										21.5										180										75										15										10										60										10										70										0.60										0.70									
Angola										2020										3.3										18.5										100										55										35										15										45										5										55										0.55										0.65									
Argentina										2020										45.0										465.0										530										75										10										8										90										25										85										0.70										0.85									
Armenia										2020										0.3										1.5										30										72										15										10										50										10										60										0.60										0.70									
Australia										2020										25.0										1350.0										1350										83										5										5										85										35										95										0.85										0.95									
Austria										2020										9.0										45.0										450										81										3										3										90										30										90										0.80										0.90									
Azerbaijan										2020										10.0										50.0										400										72										15										10										50										10										60										0.60										0.70									
Bahrain										2020										1.5										15.0										250										78										10										5										80										20										80										0.70										0.80									
Bangladesh										2020										160.0										1600.0										350										72										25										15										40										10										50										0.50										0.60									
Barbados										2020										0.3										1.5										30										78										10										5										80										20										80										0.70										0.80									
Belarus										2020										9.5										47.5										475										73										12										10										55										15										65										0.65										0.75									
Belgium										2020										11.5										57.5										575										81										3										3										90										30										90										0.80										0.90									
Belize										2020										0.5										2.5										50										75										15										10										50										10										60										0.60										0.70									
Benin										2020										25.0										125.0										50										55										35										15										45										5										55										0.55										0.65									
Bhutan										2020										0.8										4.0										80										75										10										5										80										20										80										0.70										0.80									
Bolivia										2020										11.0										55.0										350										72										15										10										50										10										60										0.60										0.70									
Bosnia and Herzegovina										2020										3.5										17.5										175										75										15										10										50										10										60										0.60										0.70									
Brazil										2020										215.0										2150.0										1100										73										20										12										55										15										65										0.65										0.75									
Bulgaria										2020										7.5										37.5										375										74										12										10										55										15										65										0.65										0.75									
Burkina Faso										2020										27.0										135.0										40										55										35										15										45										5										55										0.55										0.65									
Burundi										2020										12.0										60.0										20										52										40										15										40										5										50										0.50										0.60									
Cambodia										2020										17.0										85.0										180										72										15										10										50										10										60										0.60										0.70									
Cameroon										2020										27.0										135.0										50										55										35										15										45										5										55										0.55										0.65									
Canada										2020										38.0										1900.0										1900										82										5										5										85										35										95										0.85										0.95									
Cape Verde										2020										0.6										3.0										60										75										15										10										50										10										60										0.60										0.70									
Chad										2020										17.0										85.0										20										52										40										15										40										5										50										0.50										0.60									
Chile										2020										19.0										95.0										1900										78										10										8										80										20										80										0.70										0.80									
China										2020										1400.0										14000.0										14000										77										15										6										60										20										70										0.70										0.80									
Colombia										2020										50.0										500.0										400										75										10										8										80										20										80										0.70										0.80									
Costa Rica										2020										5.0										25.0										250										78										10										5										80										20										80										0.70										0.80									
Cote d'Ivoire										2020										26.0										130.0										60										55										35										15										45										5										55										0.55										0.65									
Croatia										2020										4.5										22.5										225										78										10										5										80										20										80										0.70										0.80									
Cuba										2020										11.0										55.0										550										77										10										5										80										20										80										0.70										0.80									
Cyprus										2020										1.2										6.0										60										80										5										3										90										25										85										0.85										0.95									
Czechia										2020										4.7										23.5										235										77										5										3										90										25										85										0.85										0.95									
Dominican Republic										2020										7.5										37.5										175										75										15										10										50										10										60										0.60										0.70									
Dominica										2020										0.1										0.5										2.5										75										10										5										80										20										80										0.70										0.80									
Ecuador										2020										17.0										85.0										180										72										15										10										50										10										60										0.60										0.70									
Egypt										2020										101.0										1010.0										500										70										20										10										50										10										60										0.60										0.70									
El Salvador										2020										6.0										30.0										300										73										15										10										50										10										60										0.60										0.70									
Estonia										2020										1.3										6.5										65										78										5										3										90										25										85										0.85										0.95									
Ethiopia										2020										115.0										1150.0										50										50										35										15										45										5										55										0.55										0.65									
Finland										2020										5.5										27.5										275										81										3										3										90										30										90										0.80										0.90									
France										2020										68.0										340.0										3400										82										3										3										90										30										90										0.80										0.90									
Gabon										2020										2.0										10.0										100										55										15										10										50										10										60										0.60										0.70									
Gambia										2020										2.0										10.0										50										55										35										15										45										5										55										0.55										0.65									
Germany										2020										83.0										415.0										4150										81										3										3										90										30										90										0.80										0.90									
Ghana										2020										27.0										135.0										60										55										35										15										45										5										55										0.55										0.65									
Greece										2020										11.5										57.5										575										78										10										8										80										20										80										0.70										0.80									
Guatemala										2020										17.0										85.0										180										72										15										10										50										10										60										0.60										0.70									
Guinea										2020										13.0										65.0										30										50										35										15										45										5										50										0.50										0.60									
Guinea-Bissau										2020										2.0										10.0										30										50										35										15										45										5										50										0.50										0.60									
Honduras										2020										9.0										45.0										450										73										15										10										50										10										60										0.60										0.70									
Hungary										2020										10.0										50.0										500										75										10										8										80										20										80										0.70										0.80									
Iceland										2020										0.4										2.0										20										83										5										3										90										25										85										0.85										0.95									
India										2020										1380.0										13800.0										13800										74										15										6										60										20										70										0.70										0.80									
Indonesia										2020										270.0										2700.0										1350										73										15										6										60										20										70										0.70										0.80									
Iran										2020										83.0										415.0										4150										75										10										8										80										20										80										0.70										0.80									
Iraq										2020										40.0										200.0										200										68										20										10										50										10										60										0.60										0.70									
Israel										2020										8.5										42.5										425										82										5										3										90										25										85										0.85										0.95									
Italy										2020										60.0										300.0										3000										83										3										3										90										30										90										0.80										0.90									
Jamaica										2020										1.2										6.0										60										75										10										5										80										20										80										0.70										0.80									
Japan										2020										126.0										630.0										6300										84										4										4										90										30										90										0.80										0.90									
Jordan										2020										10.0										50.0										500										75										15										10										50										10										60										0.60										0.70									
Kazakhstan										2020										17.0										85.0										180										72										15										10										50										10										60										0.60										0.70									
Kenya										2020										54.0										270.0										135										55										35										15										45										5										55										0.55										0.65									
Korea										2020										51.0										255.0										2550										83										4										4										90										30										90										0.80										0.90									
Kuwait										2020										4.0										20.0										200										78										10										5										80										20										80										0.70										0.80									
Kyrgyzstan										2020										0.6										3.0										30										70										15										10										50										10										60										0.60										0.70									
Laos										2020										7.0										35.0										350										72										15										10										50										10										60										0.60										0.70									
Latvia										2020										1.3										6.5										65										78										5										3										90										25										85										0.85										0.95									
Lebanon										2020										6.0										30.0										300										70										15										10										50										10										60										0.60										0.70									
Lesotho										2020										2.5										12.5										60										50										35										15										45										5										50										0.50										0.60									
Lithuania										2020										3.0										15.0										150										78										5										3										90										25										85										0.85										0.95									
Luxembourg										2020										0.6										3.0										30										82										5										3										90										25										85										0.85										0.95									
Madagascar										2020										28.0										140.0										60										50										35										15										45										5										55										0.55										0.65									
Malawi										2020										20.0										100.0										50										50										35										15										45										5																																							